# Infection Prevention and Control Lapse Report

## Royal Orchid Nails & Spa

### Initial Report

<table>
<thead>
<tr>
<th>Premise/facility under investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Orchid Nails &amp; Spa</td>
</tr>
<tr>
<td>782 Eagleson Road, Unit D7</td>
</tr>
<tr>
<td>Ottawa, ON</td>
</tr>
<tr>
<td>K2M 0N2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of premise/facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Service Setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Board of Health became aware of IPAC lapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>2023-04-18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Initial Report posting</th>
</tr>
</thead>
<tbody>
<tr>
<td>2023-05-05</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Initial Report update(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

### How the IPAC lapse was identified

In response to a public complaint regarding infection prevention and control (IPAC) in this personal service setting, OPH launched an investigation and identified an IPAC lapse.

### Summary Description of the IPAC Lapse

- Inadequate reprocessing of a pedicure device
- Multipurpose sink in reprocessing area
- Improper use of disinfectant

### IPAC Lapse Investigation

Did the IPAC lapse involve a member of a regulatory college?

No
If yes, was the issue referred to the regulatory college?
N/A

Were any corrective measures recommended and/or implemented?
Yes

Please provide further details
- Discontinue use of the pedicure device until proper reprocessing can be verified
- Provide disinfectant suitable for disinfecting the pedicure tool
- Use disinfectants according to the manufacturer’s instruction
- Designate a sink for reprocessing

Date any order(s) or directive(s) were issued to the owners/operators (if applicable)
On 2023-04-19, as instructed by OPH, the practitioner discontinued use of pedicure devices until they could be reprocessed adequately

Initial Report Comments and Contact Information

Any Additional Comments
On 2023-04-20 there was no evidence of use of the pedicure device.

If you have any further questions, please contact:
Title: Michelle Wasser, Program Manager
Infection Prevention and Control - Inspection and Investigation
Ottawa Public Health

E-mail address: IPAC/PCI@ottawa.ca
Phone number: 613-580-2424 ext. 26325

For general updates regarding this investigation, continue to monitor this report.
The results of routine inspections are posted on the Ottawa Public Health Disclosure website.

Final Report

Date of Final Report posting:

Date of Final Report Update(s)
Date all corrective measures were confirmed to have been completed

Brief description of corrective measures taken

Final Report Comments and Contact Information

Any Additional Comments

If you have any further questions, please contact:

**Title:** Michelle Wasser, Program Manager  
Infection Prevention and Control - Inspection and Investigation  
Ottawa Public Health

**E-mail address:** [IPAC/PCI@ottawa.ca](mailto:IPAC/PCI@ottawa.ca)

**Phone number:** 613-580-2424 ext. 26325